#3

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

accepted

PRINTED: 09/15/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445439	A. BUILDING _____ B. WING _____	C 08/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT JULIET HEALTH CARE CENTER	2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS During complaint investigation of TN00028497 and TN00028515, on August 22 - 29, 2011, at Mt. Juliet Health Care Center, no deficiencies were cited in relation to complaint TN00028515 under 42 CFR PART 482.13, Requirements for Long Term Care.	F 000	F323 Amended POC F323.25(h) Free of accident hazards/supervision/devices SS=G Requirement:	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility investigation review, and interview, the facility failed to take appropriate measures to prevent accidents with one (#1) of eleven residents reviewed. The failure to take appropriate safety measures results in actual harm to the resident. Medical record review revealed resident #1 was admitted to the facility on December 10, 2008 with diagnoses to include Hypertension, Gastroesophageal Reflux Disease, and Dementia. Review of the Minimum Data Set dated May 21, 2011, revealed the resident had a BIMS (Brief Interview for Mental Status) score of 3, or severe	F 323	The facility will take appropriate measures to prevent accidents Corrective action: 1. On 8/23/11 The Certified Nursing Assistant was in-serviced by the Risk Management Nurse about Resident rights in regards to refusing care. On 8/1/11 and 8/6/11 the Staff was in-serviced by the Risk Management Nurse regarding re-approaching a resident when they are refusing care. 2. An audit was completed by 9/29/11 on all residents to determine who could safely propel themselves without foot rests on the chair. This was done by the Risk Management nurse who reviewed the careplan and physically checked each resident. Those residents who could not propel themselves had foot rest put on their wheel chairs for positioning prior to being propelled by staff.	10/7/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Frances Sloyi | TITLE: Administrator | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445439	A. BUILDING _____ B. WING _____	C 08/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT JULIET HEALTH CARE CENTER	2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 1 cognitive deficits. Continued review revealed the resident required assist of two persons for transfer; required extensive assistance for bathing, dressing, and grooming; was incontinent of bowel and bladder; was able to eat after set-up. Review of a facility Nurse's Event Note dated July 29, 2011, revealed the nurse was called to the resident's room by the CNA (Certified Nursing Assistant). Continued review revealed "... walked in room and observed res. (resident) lying face down actively bleeding copious amounts of blood from nose and mouth; laceration noted to bridge of nose and top lip. Res. c/o (complained of) pain to head. Couldn't recall what happened. This nurse called 911; res was transported to ... (named hospital) via ambulance...". Review of the facility investigation revealed "Resident put feet down when being assisted with staff with w/c (wheelchair) mobility and fell forward out of w/c...". Appropriate interventions included "... Staff educated to reapproach with refusals of assist from staff...". Review of the Occurrence Investigation Statement written by the CNA assisting the resident and dated July 29, 2011, revealed "... I began to wheel the patient in ... room to go to dinner. As I began to turn ... in ... wheelchair and go forward the patient said ... did not want to go, ... feet were slightly on the floor as I proceeded slowly to turn ... and go forward ... fell. I immediately went for help...". Review of the physician's report dated July 29, 2011, revealed the resident was diagnoses with	F 323	3. The resident's mobility status was added to the resident careplan during the audit and was completed by 9/29/11 by the Risk management nurse. Currently the facility is going to a computerized ADL record. A resident profile is being entered on each resident. The resident's mobility status will be added to the resident's profile by 10/7/11 by the Administrator and DON to insure staff is aware of mobility needs. 4. Risk Management and DON/ADON will monitor staff for compliance by walking rounds and observations. If a change is determined thru walking rounds or observation the updated intervention will be added to the resident's profile and careplan. Inservice on the change will done to insure staff is aware of the changes. The walking rounds and observations will be reviewed, analyzed and given to the QA committee quarterly for compliance. If it is determined that further change needs to occur, the change will be made to the resident's profile and inservice will be done to update staff on any changes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445439	A. BUILDING _____ B. WING _____	C 08/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT JULIET HEALTH CARE CENTER	2660 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 2 left nasal fracture/laceration as well as "... segmental closed humeral shaft fracture with displacement and radial neck fracture...". The resident's POA agreed with closed nonsurgical management of the elbow fracture but fixation of the humeral fracture. Interview with the Physical Therapist on August 22, 2011, at 3:00 p.m., in the conference room, revealed foot rests are not used on all wheelchairs. Continued interview revealed it the resident can hold the feet up then foot rests are not used. Further interview revealed holding the feet up is a good isometric exercise. Continued interview revealed if the lower extremities are weak then the resident needs foot rests. Further interview revealed the Physical Therapist was unable to recall the resident. Interview with the administrator on August 22, 2011, at 3:20 p.m., in the conference room revealed the resident was unable to hold the feet off the floor. Continued interview revealed foot rests have been applied to the resident's wheelchair and now the resident is pushed to and from meals. Telephone interview on August 23, 2011, with the CNA pushing the resident in the wheelchair on July 29, 2011, when the accident occurred, revealed "I went to the dining room and realized the resident was not there. I was asked to go and get ... and ... was facing the window. I told ... I was taking ... to the dining room. As I was turning the chair around ... put feet down and said "no". As I turned ... and moved forward ... fell. I hadn't gone a foot with ... If we had gone further I would have told ... to lift up feet. This was the first time	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445439	A. BUILDING _____ B. WING _____	C 08/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MT JULIET HEALTH CARE CENTER	2650 NORTH MT JULIET ROAD MOUNT JULIET, TN 37122

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 3 ... said no. I had moved her before and ... lifted up feet".	F 323		